Quality Management Tools

The CAP’s comprehensive collection of Quality Management Tools (QMT) strengthens your knowledge of key laboratory processes, identifies quality improvement opportunities, and provides the information you need for effective laboratory management:

**Q-PROBES™** In-Depth Quality Assessment Program
**Q-TRACKS®** Continuous Quality Monitoring Program
**LMIP®** Laboratory Management Index Program
**CAP LINKS™** The Laboratory Integrated Knowledge Source

The CAP’s Quality Management Tools help you:
- **Identify** quality improvement opportunities and monitor progress over time
- **Establish** realistic goals for your laboratory using a set of customized external benchmarks
- **Demonstrate** the ability to meet accreditation requirements

*Integrate QMT into your daily activities to support your quality improvement initiatives!*
Q-PROBES and Q-TRACKS offers a comprehensive collection of tools to complement your quality management program needs.*

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*The CAP requires accredited laboratories to have a quality management plan that covers all areas of the laboratory and includes benchmarking key measures of laboratory performance (GEN.13806, 20316). The Joint Commission requires accredited hospitals to regularly collect and analyze performance data (PI.01.01.01, PI.02.01.01). CLIA requires laboratories to monitor, assess, and correct problems identified in preanalytic, analytic, and postanalytic systems (§493.1249, §493.1289, §493.1299).
Q-PROBES

A Program for In-depth Comprehensive Assessment

Evaluate quality improvements in your lab – With today’s focus on reducing medical errors, achieving and maintaining excellence is key to success. Using short-term studies, Q-PROBES provides a one-time comprehensive assessment of key processes in your laboratory.

Structure your data collection and analysis for success – Use Q-PROBES to help build and improve data collection and analysis processes that contribute to quality of care, patient safety, and outcomes.

Establish realistic laboratory benchmarks and performance goals – Q-PROBES is an external peer-comparison program that addresses process-, outcome-, and structure-oriented quality assurance issues. Establish benchmarks through external database comparisons and compare your performance to that of peer organizations to establish laboratory goals and improve performance.

Q-PROBES offers CME/CE credit to all laboratory staff to help you build a solid foundation of education and knowledge within your organization.

Examine the effectiveness of key processes with Q-PROBES.
Technical Staffing Ratios  QP101

Staff accounts for two-thirds of direct clinical laboratory costs and management of staffing levels is central to managing overall laboratory expenses. In this study, key staffing ratios are calculated for four different laboratory testing sections (anatomic pathology, chemistry/hematology/immunology, microbiology, and transfusion medicine) and participants are provided with information about staffing levels for all participating institutions.

Objective
Measure staffing in different areas of the laboratory, calculate key staffing ratios, and compare key staffing ratios with other institutions.

Data Collection
Participants will use their laboratory or institution’s revenue and usage reports to obtain billable test counts and staffing figures for the most recently completed fiscal year for four key laboratory testing sections.

Performance Indicators
- Anatomic pathology indicator: histology blocks/histotechnologist, cytology accessions/cytotechnologist
- Chemistry/hematology/immunology indicator: billable tests/non-management FTE
- Microbiology indicator: billable tests/non-management FTE
- Transfusion medicine indicator: crossmatches and type and screens/non-management FTE
Utility of Repeat Testing of Critical Values  QP102

Both CAP's Laboratory Accreditation Program and The Joint Commission require laboratories to have mechanisms in place to communicate critical values in a timely and accurate manner to clinical care providers. A common laboratory practice is to repeat critical values before reporting the test results to the clinical care provider. With today's modern instrumentation, this may be an unnecessary step that delays the reporting of critical test results without adding value to the quality or accuracy of the test result.

**Objective**
Determine the rate of repeated values changed from a critical to a non-critical value, the rate of repeated chemistry and hematology values that differed significantly from the original value as defined by the participating laboratory, the threshold differences defined by the laboratory as clinically significant, and the additional time required to analyze the repeated test.

**Data Collection**
For potassium, glucose, WBC count, and platelet counts, identify 40 consecutive, repeated critical results and record the following:
- Initial and repeated test results
- If the repeated test result was significantly different as defined by your laboratory
- If the repeated test result was still considered a critical value
- Time the initial and repeated tests resulted from the analyzer
- Time of critical result notification

Record the total number of critical results that were reviewed and provide a list of the analytes for which the laboratory defines a critical value. Point of care testing is excluded from this study.

**Performance Indicators**
- Rate of repeated results that met the criteria for a critical result
- Rate of repeated results that were significantly different from the original value, according to institutional policy

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College of American Pathologists
800-323-4040 Option 1 for Customer Contact Center
Objective
Determine how laboratories monitor INR calculations, patient values, and reference ranges (per HEM.23430) and determine the percentage of critical PT/INR results that are successfully provided to a licensed caregiver.

Data Collection
Perform an audit of the laboratory’s most recent PT test validation to determine if the five required validation components for correct INR calculations were incorporated and documented. The five validation components are:

1. Change in (most recent) lot or type of PT reagent recorded and compared to prior lot
2. Change of instrumentation recorded and compared to prior instrument (if applicable)
3. Establishment of the most recent PT reference range
4. INR calculation validation
5. At defined intervals, PT/INR results and calculations are audited

In addition, prospectively review 40 critical PT/INR results occurring over a three-week period (or if less than 40 are received, the total number of critical PT/INR results) to determine the number that were successfully reported to a licensed caregiver with read-back.

A survey will also include questions related to the prevalence of PT/INR point of care testing, how inter- and intra-laboratory comparisons are performed for PT/INR tests, the current critical values, turnaround times for PT/INR, and additional laboratory anticoagulation practices.

Performance Indicators
Primary:
• Percentage of successfully communicated PT/INR critical results to the responsible caregiver

Secondary:
• Percentage of required validation components for correct INR calculations documented for the most recent PT test validation
Mammography Correlation with Pathology Reports  QP104

A benign diagnosis in a surgical specimen in the setting of a radiographically suspicious abnormality may be due to a non-representative sample, and lack of recognition of discordance by the clinical team may lead to a delay in diagnosis. This is of particular importance with breast lesions. Correlation of findings in the surgical pathology report with radiologic findings is important for quality patient care.

Objective
Determine the rate that surgical pathology reports correlate histologic abnormalities with radiographic findings.

Data Collection
Retrospectively review 40 surgical reports for correlation of the histologic findings with radiologic findings. Participants will be asked to tabulate the number of specimens for which radiologic findings were available and the number of cases that contained specific histologic findings that correlated with the radiographic findings. Specific radiographic findings (ie, calcifications, multiple abnormalities) will also be assessed for notation in the final surgical pathology report.

Performance Indicators
Primary:
• Rate of pathologic-radiologic correlation in surgical pathology reports of breast biopsies

Secondary:
• Rate of pathologic-radiologic correlation of specific radiographic lesions (calcifications, mass, multiple lesions, etc.) in surgical pathology reports
• Rate of breast specimens received with specific radiographic abnormality noted on the requisition slip
Q-TRACKS

A Program of Continuous Quality Monitoring

Observe performance trends over time to identify and monitor opportunities for quality improvement through quantitative quality measures. Q-TRACKS offers continuous quality monitoring with longitudinal tracking of performance and key indicators for clinical and anatomic pathology.

**Step 1:**
Establish realistic benchmarks by comparing your laboratory to others like yours.

Q-TRACKS offers CME/CE credit for all laboratory staff each quarter to help you build a solid foundation of education and knowledge within your organization.

**Step 2:**
Identify improvement opportunities.

**Step 3:**
Monitor improvement over time to ensure accurate diagnosis, patient safety, and quality patient care.
**Q-TRACKS Clinical Pathology Monitors**

### Patient Identification Accuracy  QT1

**Objective**  
Assess the incidence of wristband errors within individual institutions, compare performance between participating institutions, and identify improvement opportunities.

**Data Collection**  
On six predetermined days per month, participants will monitor patient wristband identification for all phlebotomies performed at their institution. Phlebotomists will tally the total number of wristbands checked, the number of errors found, and the types of wristband error. This monitor includes all routinely wristbanded patients. (Emergency department patients are included only if the emergency department routinely applies wristbands to these patients.)

**Performance Indicator**
- Wristband Error Rate (%)

**Performance Breakdown**
- Breakdown of Wristband Error Types (%)

### Blood Culture Contamination  QT2

**Objective**  
Determine the rate of blood culture contamination using standardized criteria for classifying contaminants.

**Data Collection**  
On a monthly basis, participants will tabulate the total number of blood cultures processed and the total number of contaminated blood cultures. For the purposes of this study, participants will consider a blood culture to be contaminated if one or more of the following organisms are found in only one of a series of blood culture specimens: Coagulase-negative *Staphylococcus*; *Micrococcus*; Alpha-hemolytic (viridans) *Streptococci*; *Propionibacterium acnes*; *Corynebacterium* sp. (diptheroids); or *Bacillus* sp. Optional institution-specific subgroups may be used to track parameters that may affect contamination rates. Neonatal totals are tabulated separately from other blood cultures.

**Performance Indicators**
- Overall Contamination Rate (%)
- Neonatal Contamination Rate (%)
- Other Contamination Rate (%)

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Input forms for quarterly data collection will be sent to participants approximately three weeks prior to the quarter.
**Laboratory Specimen Acceptability  QT3**

A substantial amount of rework, diagnostic and therapeutic delay, and patient inconvenience can result from specimen rejection. Patient redraws may be due to issues including unlabeled, mislabeled, and incompletely labeled specimens; clotted and/or hemolyzed specimens; and insufficient specimen quantity. By continuously monitoring specimen acceptability, collection, and transport, problems can be promptly identified and corrected, leading to improved patient care. Participation in this monitor can help satisfy the CAP’s checklist question GEN.20348, “Are preanalytic processes monitored?”

**Objective**
Identify and characterize unacceptable blood specimens that are submitted to the chemistry and hematology sections of the clinical laboratory for testing.

**Data Collection**
This monitor includes all blood specimens submitted for testing to the chemistry and hematology departments of the clinical laboratory. Weekly tallies of the total number of specimens received, the number of rejected specimens, and the primary reason each specimen was rejected will be recorded.

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**In-Date Blood Product Wastage  QT4**

Blood for transfusion is a precious resource. At a minimum, wastage of blood that is not out-of-date represents a financial loss to the health care system. More ominously, systemic wastage of blood may reflect an environment of care that is out of control and could pose risks to patient safety.

**Objective**
Compare the rates of blood product wastage (ie, units discarded in-date) in participating hospitals and track rates of improvement over time.

**Data Collection**
On a monthly basis, participants will use blood bank records to obtain information on the total number of units transfused for each type of blood component. Participants will track the number and type of blood units that are wasted in-date and the circumstances of wastage. The following types of blood components will be included: whole blood (allogeneic); red blood cells (allogeneic); frozen plasma; platelet concentrates; single donor platelets; and cryoprecipitate.

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Input forms for quarterly data collection will be sent to participants approximately three weeks prior to the quarter.
Satisfaction with Outpatient Specimen Collection  QT7

Specimen collection is one of the few areas of laboratory medicine that involves direct outpatient contact. As a result, patient satisfaction with this service is a vital indicator of quality laboratory performance. By participating in this monitor, you can help ensure that patient satisfaction with laboratory services is being measured as required by accrediting agencies such as The Joint Commission and the CAP (GEN.40050, 20348).

**Objective**
Assess patient satisfaction with outpatient phlebotomy services by measuring patients’ assessment of waiting time, discomfort level, courteous treatment, and overall satisfaction.

**Data Collection**
On a monthly basis, participants will distribute copies of a questionnaire to a minimum of 25 outpatients (maximum of 99 outpatients), using predetermined data collection criteria. This monitor includes any outpatient undergoing venipuncture or for whom assistance was required in specimen collection by your laboratory staff. This monitor excludes patients seen in the emergency department, ambulatory surgery area, urgent care facility, chest pain center, 23-hour short-stay facility, employee health department, outpatient health screening fair/promotion, dialysis center, nursing home, or extended care facility.

**Performance Indicators**
- Overall Patient Satisfaction Score
- Patients “More Than Satisfied” (%)

Stat Test Turnaround Time Outliers  QT8

Measuring laboratory stat test turnaround time (TAT) is useful to the laboratory in evaluating the service delivery process. The stat test TAT outlier rate, expressed as a percent of tests missing target reporting times, is a measure of outcomes that evaluates how well the laboratory meets patient and clinician needs. This monitor helps meet CAP checklist question GEN.20316, “Does the QM program include monitoring key indicators of quality?“

**Objective**
Monitor the frequency with which stat test TAT intervals exceed institutional stat test TAT expectations.

**Data Collection**
Before beginning data collection, participants will establish a specimen receipt-to-report deadline for emergency department (ED) stat potassium tests. On six predetermined days per month, participants will monitor the TAT of up to 10 randomly selected ED stat potassium tests on each of three eight-hour shifts (up to 180 tests per month) and track the number of ED stat potassium determinations reported later than the established reporting deadline. This monitor includes stat potassium tests ordered as part of a panel and excludes stat potassium levels that are requested on body fluids other than blood, as part of timed or protocol studies, or after the specimen arrives in the laboratory.

**Performance Indicator**
- Stat Test TAT Outlier Rate (%)

**Performance Breakdowns**
- Breakdown of Outliers by Shift (%)
- Breakdown of Outliers by Day of Week (%)

Input forms for quarterly data collection will be sent to participants approximately three weeks prior to the quarter.
Critical Values Reporting  QT10

Critical values in the laboratory are defined as results requiring immediate notification to the physician or caregiver for necessary patient evaluation or treatment. While critical value notification has been a routine practice in laboratory medicine for many years, recent regulations from agencies and accreditors such as CMS, The Joint Commission, and the CAP (GEN.20316, 20365, 41320) have mandated that laboratories develop and implement an alert system for critical values. Use this monitor to document compliance with your laboratory’s alert plan.

Objective
Evaluate the documentation of successful critical values reporting in the general laboratory for both inpatients and outpatients according to the laboratory’s policy.

Data Collection
On a monthly basis, participants will evaluate 120 inpatient and 120 outpatient critical values for the designated sections. Data collection will include general chemistry, hematology, and coagulation analytes on the critical values list. Retrospectively, participants will record the total number of critical values monitored and if there was documentation of notification. This monitor will exclude critical values for microbiology, cardiac markers, drugs of abuse, therapeutic drug levels, urinalysis, blood gases, point of care tests, tests performed at reference laboratories, and critical values on discharged patients.

Performance Indicators
- Total Critical Values Reporting Rate (%)
- Inpatient Critical Values Reporting Rate (%)
- Outpatient Critical Values Reporting Rate (%)

Turnaround Time of Troponin  QT15

The swiftness with which physicians establish diagnoses of acute myocardial infarction (AMI) in patients presenting to the emergency department (ED) with chest pain may determine the type and predict the outcomes of therapy those patients will receive. Included in the total time consumed in establishing diagnoses of AMI are the component intervals required to measure biochemical markers of myocardial injury, one of the most critical of which is troponin. Help meet CAP checklist question GEN.20316 with this monitor.

Objective
Determine the median order-to-report turnaround time (TAT) of troponin (I or T) and the percent of troponin results reported by each institution’s established deadline.

Data Collection
Participants will record the TATs (in minutes) for three randomly selected troponin specimens obtained from patients seen in EDs on each of three traditional shifts (total of nine measurements) on six pre-determined days per month. TATs will be measured from the times the tests are ordered to the times that results are made available to ED personnel. Participants will also have the option of monitoring collection-to-receipt intervals.

Performance Indicators
- Median Troponin Order-to-Report TAT (minutes)
- Troponin TAT Compliance Rate (%)
Corrected Results  QT16

This Q-TRACKS monitor was developed in recognition of the importance of timely detection and correction of erroneous laboratory results. Accuracy in laboratory results is critical to the effectiveness of a physician’s plan of care for a patient. An erroneous result can delay or alter patient treatment; therefore, detection of erroneous results should be a priority in every laboratory and should be monitored as a key quality indicator. Help measure your compliance with CLIA 493.1299, Postanalytic Systems Quality Assessment, with this monitor.

Objective
Monitor the number of corrected test results within individual institutions and compare performance with that of all institutions and those institutions similar to yours.

Data Collection
On a monthly basis, participants will monitor the number of corrected test results and the total number of billable tests for that month. Test results for all patients in all care settings will be included, with the following exclusions: anatomic pathology tests, narrative physician-interpreted tests (ie, bone marrow biopsies and peripheral smear reports), and point of care tests.

Performance Indicator
- Test Result Correction Rate (per 10,000 billable tests)

Outpatient Order Entry Errors  QT17

Order accuracy bears an obvious relationship to the quality of laboratory testing. When the laboratory fails to complete a requested test, the diagnostic evaluation is delayed, potentially extending a patient’s hospital stay and prolonging therapy. When the laboratory completes a test that was not requested, the cost of care increases, patients may be subjected to unnecessary phlebotomy, and laboratory efficiency declines.

Objective
Measure the incidence of incorrectly interpreted and entered outpatient physician test orders into the laboratory computer, compare performance across institutions, and track performance over time.

Data Collection
On six pre-selected weekdays per month, eight outpatient requisitions or order sheets will be compared to the orders entered into the laboratory’s information system to determine if any order entry errors occurred. Order entry error categories include requesting physician error, incorrect, missing, and extra test errors, test priority errors, and non-routine routing request errors. Tests performed in transfusion medicine/blood bank or anatomic pathology are excluded.

Performance Indicators
- Outpatient Order Entry Error Rate (%)
- Order Entry Error Rates by Type (%)

Performance Breakdown
- Breakdown of Error Types (%)

Input forms for quarterly data collection will be sent to participants approximately three weeks prior to the quarter.
Specimen Acceptability in Blood Bank  QT18

Appropriate collection and labeling of patient specimens are essential for accurate specimen analysis and reporting of test results. Mislabeling of blood bank specimens can result in catastrophic outcomes when incompatible red blood cells are transfused. Accrediting agencies, such as AABB and the CAP (TRM.30550, 30575), require monitoring of key specimen quality issues and demonstration of a system for continual process improvement. This Q-TRACKS monitor will allow you to compare your performance to your peers.

Objective
Identify and characterize incorrectly collected and labeled blood specimens submitted to the blood bank for testing.

Data Collection
Participants will provide weekly tallies of the total number of specimens submitted to the blood bank and the number of rejected specimens. The primary reason for specimen rejection will be reported, based on the following categories:

- Wrong collection container
- Unlabeled specimen
- Incompletely labeled specimen
- Mislabeled specimen
- Requisition does not match specimen
- Specimen hemolyzed
- Specimen clotted
- Insufficient specimen volume
- Duplicate specimen
- Specimen with any suitability concerns later reported by caregivers
- Other reason for rejection (ie, broken specimen)

Performance Indicators
- Specimen Rejection Rate (%)
- Breakdown of Rejection Reasons (%)

Input forms for quarterly data collection will be sent to participants approximately three weeks prior to the quarter.
Objective
Quantify the correlation between the findings of cervicovaginal cytology and corresponding histologic material.

Data Collection
On a monthly basis, participants will record information on true-positive, false-positive, and false-negative cytology-biopsy correlations. False-negative correlations will be separated into four error categories. Participants will record the biopsy diagnoses for Pap tests with an interpretation of atypical squamous cells (ASC-US and ASC-H) or atypical glandular cells (AGC). This monitor includes patients for whom a cervical biopsy specimen is submitted to the laboratory and for whom a satisfactory or satisfactory but limited Pap test has been submitted within three months previous to the biopsy or at the time of the biopsy.

Performance Indicators
• Predictive Value of Positive Cytology (%) 
• Sensitivity (%) 
• Screening/Interpretation Sensitivity (%) 
• Sampling Sensitivity (%) 
• Percent Positive for ASC-US Interpretations 
• Percent Positive for AGC Interpretations 
• Percent Positive for ASC-H Interpretations 

The correlation of cervicovaginal cytology (Pap test) findings with cervical biopsy results has been a staple in the cytopathology laboratory’s quality assurance program. By monitoring this correlation, the laboratory can identify potential problems that require improvement, thereby ensuring better patient results.

Input forms for quarterly data collection will be sent to participants approximately three weeks prior to the quarter.
Laboratory Management Index Program

Manage your laboratory more effectively with LMIP – The Laboratory Management Index Program (LMIP) is an effective fiscal management tool that provides you with a valuable peer comparison of your laboratory’s performance. LMIP can assist you with the annual budget process, contract negotiations, and daily operations management.

With over 10 years of experience and the largest laboratory participant database, LMIP is the best management resource for health care professionals charged with decision-making responsibilities. Using management ratios as performance indicators, LMIP extends beyond traditional analysis of productivity and staffing to focus on the most important factors affecting laboratory performance:

- **Productivity** – How effectively are you using your laboratory personnel?
- **Utilization** – How do your test-ordering patterns compare to those of your peers?
- **Cost-effectiveness** – How efficiently are you using your supplies, equipment, and labor?

With LMIP’s statistically valid method of peer grouping (fingerprint clustering), you receive the most meaningful comparisons. These comparisons allow you, your colleagues, and your administration to make informed and realistic decisions about staffing, budgets, and other performance targets.

Achieving quality test results involves more than just ensuring that tests are conducted properly. Understanding financial factors that drive laboratory processes enhances your confidence in the management decisions you make. Ultimately, these decisions will guide your organization to deliver superior patient care.
The Laboratory Management Index Program (LMIP) input items are collected and analyzed quarterly to provide a report of your laboratory’s overall operations. The data collected is used to generate relevant management ratios that provide analysis of the productivity of personnel, laboratory policies and procedures, salary and other expenses, physician test utilization, and organizational benefits.

The input items you will collect include:

<table>
<thead>
<tr>
<th>Blood Expense</th>
<th>Outpatient Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consumable Expense</td>
<td>Referred SBTs</td>
</tr>
<tr>
<td>Equipment Depreciation Expense</td>
<td>Referred SBT Expense</td>
</tr>
<tr>
<td>Equipment Maintenance and Repair Expense</td>
<td>Testing Labor Expense</td>
</tr>
<tr>
<td>Hospital Inpatient Days</td>
<td>Total Labor Expense</td>
</tr>
<tr>
<td>Hospital Inpatient Discharges</td>
<td>Total Laboratory Paid Hours</td>
</tr>
<tr>
<td>Inpatient SBTs</td>
<td>Total Laboratory Worked Hours</td>
</tr>
<tr>
<td>Nonpatient SBTs</td>
<td>Total SBTs</td>
</tr>
<tr>
<td>On-Site SBTs</td>
<td></td>
</tr>
<tr>
<td>Outpatient SBTs</td>
<td></td>
</tr>
</tbody>
</table>

The Standardized Billable Test (SBT) is the primary unit of measure for LMIP. The SBT is a method of standardizing test counts and eliminates billing, accounting, and interpretation variations to ensure valid comparisons are created.
CAP LINKS

The Integrated Knowledge Source

Consolidate proficiency testing, accreditation, and quality improvement data for your entire organization into concise and actionable reports.

CAP LINKS is designed for multihospital systems, academic medical centers with numerous testing locations, and national commercial reference laboratories. CAP LINKS provides a high-level overview useful in identifying improvement opportunities and demonstrating good QI performance. CAP LINKS data is accessed directly from the CAP laboratory improvement database. Therefore, no additional data submission is required. CAP LINKS is available for all of your CAP laboratory improvement programs, including:

- Surveys & Anatomic Pathology Education Programs and EXCEL®
- Laboratory Accreditation Program
- Q-TRACKS Program
- LMIP – Laboratory Management Index Program

CAP LINKS has been enhanced to provide you the ability to do the following:

- Download data and manipulate reports to accommodate your specific institution’s needs
- Use e-mail to forward one or all reports to appropriate individuals for viewing
- Designate viewing options to select individuals via the CAP Web site directly
- Receive CAP LINKS reports more promptly via the Web—your printed reports will continue to be forwarded via regular mail
- Respond to exceptions in a timelier manner

The report package allows you to quickly see good performance and identify sites that may require special attention, both at the laboratory level and at the system or corporate level.

Reports are generated on a quarterly basis and distributed by mail and via the Internet to an individual whom you designate as your system’s primary contact. Annually, your primary contact will receive an overview of the system’s full-year performance for proficiency testing. Online reports are secure and viewable by those individuals with granted viewing privileges.
Quarterly reports summarize PT systemwide average results by discipline to allow for interlaboratory comparisons.

Accreditation reports recap inspection findings for each laboratory.
Quality Management Tools Pricing Overview

### 2010 Q-PROBES

<table>
<thead>
<tr>
<th>Modules/Package</th>
<th>Product Codes</th>
<th>Price</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual QP Studies</td>
<td>QP101, QP102, QP103, QP104</td>
<td>$395 each</td>
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<tr>
<td>All Four QP Studies</td>
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### 2010 Q-TRACKS

<table>
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<th>Modules/Package</th>
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<tr>
<td>Individual Clinical Pathology (CP) Monitors</td>
<td>QT1, QT2, QT3, QT4, QT7, QT8, QT10, QT15, QT16, QT17, QT18</td>
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<td>Individual Anatomic Pathology (AP) Monitor</td>
<td>QT5</td>
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<td>Combined CP/AP Module – Includes all 12 QT Monitors</td>
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<td>Clinical Pathology Module – Includes all 11 CP Monitors</td>
<td>QTC</td>
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<tr>
<td>Patient Safety Module – Includes QT1, QT2, QT10, QT15, QT16, QT17</td>
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### 2010 Laboratory Management Index Program

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<tr>
<td>LMIP</td>
<td>LMB</td>
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### 2010 CAP LINKS

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<th>Combination Program Options</th>
<th>Product Codes</th>
<th>Surveys/EXCEL</th>
<th>LAP</th>
<th>Q-TRACKS</th>
<th>LMIP</th>
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<tbody>
<tr>
<td>Option 1</td>
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<td>Option 2</td>
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<table>
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<tr>
<th>Individual Program Options</th>
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<td>Laboratory Accreditation Program</td>
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<tr>
<td>Q-TRACKS</td>
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</tr>
<tr>
<td>LMIP</td>
<td>IMRLM</td>
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</tbody>
</table>
Tools to Help You Manage Your Workload

- Alerts you that your PT products have shipped
- Link to track your shipment
- Results in less worries

- Access your time-critical evaluation of Linearity Reports within two business days of data submission
- Available through e-LAB Solutions™

- Saves valuable time, getting results up to 10 days sooner
- Minimizes PT failure with pre-populated electronic forms and drop-down menus
- Eliminates clerical errors due to scanning or faxing
- Manages your workload with timely e-mail reminders for data submission and result reporting

- Provides ongoing information about all divisions of the College of American Pathologists (CAP)
- Available for review on the CAP Web site by selecting the Accreditation and Laboratory Improvement tab

- Provides regulatory and other important information relative to CAP products and services
- Contains time-sensitive implications for laboratories
The CAP is committed to the success of pathologists and the laboratory community, both for today and tomorrow. We’ve recently launched a multiyear transformation effort to create an enhanced and evolved role for pathologists over the next generation—yielding a greater recognition as physicians actively involved on the patient care team.

Learn more at cap.org/transformation
College of American Pathologists
325 Waukegan Road
Northfield, IL 60093-2750
800-323-4040 or
847-832-7000 option 1
www.cap.org

Programs and Resources

Accreditation
Offers the "gold standard" for laboratory accreditation

Proficiency Testing
Ensures precision and confidence for your lab

CAP 15189 SM
Recognizes a sustainable Quality Management System

Education
Serves as a leading resource for information and education in the lab

Efficiency/Quality Tools
Allows more time for patient care

Advocacy
Represents the interests of pathologists in the government and regulatory arenas and in the private sector

Membership
Provides valuable benefits and leadership for all laboratory professionals

SNOMED Terminology Solutions™
Provides clinical and technical consultation services, education, and health information technology